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IN THE UTAH COURT OF APPEALS

BRENDA E. RIVERA, Appellant, v. CLAYTON S. WILDE, M.D., Respondent.	COURT OF APPEALS Appeal No. 930366-CA (Consolidated Cases)
ANTONIO R. RIVERA, By and Through his Guardian Ad Litem, TONY RIVERA, also known as Antonio R. Rivera, Appellant, v. CLAYTON S. WILDE, M.D., Respondent.	Priority No. 15 930366-CA

APPELLANT'S BRIEF

**Appeal from the Judgment of the Honorable Michael Murphy,
Judge of the Third Judicial District Court
Salt Lake County, State of Utah**

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JURISDICTION OF THIS COURT

The Court of Appeals of the State of Utah has jurisdiction over this matter by virtue of Utah Code Annotated §78-2a-3(2)(k) (1992), as an appeal of a civil matter from a final judgment of a district court, where the case has been transferred to the Court of Appeals by the Supreme Court.

STATEMENT OF ISSUES PRESENTED ON APPEAL

1. Was there sufficient evidence for the court to find that Dr. Wilde subscribed to a safe standard of care by following an alleged school of thought that rigidly defines the dangerous medical condition of preeclampsia as blood pressure of 140/90 in the presence of proteinuria, and which allows Dr. Wilde to delay treatment until the patient reaches said standard, when the undisputed evidence is that many preeclamptic women progress to eclampsia (convulsions) without ever having proteinuria or blood pressure of 140/90? Did the court err in finding that the plaintiff did not demonstrate by a preponderance of the evidence that the school of thought defendant followed in his treatment of plaintiff is unsafe?

2. Where two schools of thought exist for diagnosing and treating the dangerous medical condition known as preeclampsia, and one of the schools is unsafe for a significant category of pregnant women including the plaintiff, does Dr. Wilde's conduct in following the unsafe school of thought fall below the legal standard of care even though a significant number of other doctors in the community follow that unsafe standard? Stated another way, where the defendant

suspected that plaintiff had preeclampsia when he examined her on June 15, 1989, and the undisputed evidence is that preeclampsia is a dangerous medical condition which can progress rapidly and have severe consequences, did the court err in not finding Dr. Wilde's standard to be unsafe when he instructed the plaintiff to return for re-examination in two weeks, and failed to warn her that she could have a serious, life-threatening condition, and should take steps to protect herself?

STANDARD OF APPELLATE REVIEW

This case was tried to the court. Therefore, Utah Rule of Civil Procedure 52(a) provides: "Findings of fact, whether based on oral or documentary evidence, shall not be set aside unless clearly erroneous, ..." A finding is deemed to be "clearly erroneous" if the Court of Appeals concludes that the finding is against the clear weight of the evidence. Robb v. Anderton, 225 Ut. Adv. Rptr. 22 at 25 (Ut. App. 1993). The evidence is reviewed in a light most favorable to the trial court's findings and is affirmed if there is a reasonable basis for doing so. Conversely, if there is no reasonable basis for doing so, the verdict need not be affirmed. Id. Factual findings may also be set aside if this court reaches "a definite and firm conviction that a mistake has been made." State v. Walker, 743 P.2d 191 (Utah 1987).

As a prerequisite to an attack on findings of fact, the appellant must marshal all the evidence in support of the findings and demonstrate "that the evidence, including all reasonable inferences drawn therefrom, is insufficient to

support the findings ...." Grayson Roper Ltd. v. Finlinson, 782 P.2d 467, 470 (Utah 1989). The marshaling requirement supplies the Court of Appeals with a basis on which to conduct a meaningful and expedient review of facts challenged on appeal.

STATUTORY PROVISIONS

There are no substantive statutory provisions that are relevant to a determination of this case.

SUMMARY OF ARGUMENT

The trial court failed to find that the standard of care followed by Dr. Wilde was unsafe, despite undisputed, unchallenged evidence that it was unsafe. Dr. Wilde's standard was unsafe as a matter of law.

Undisputed facts justify these bold statements. Brenda Rivera, age 25, was at the end of the 6th month of her first pregnancy at the time of her examination on June 15, 1989. Her diastolic blood pressure, which is more sensitive than systolic to the development of preeclampsia, had increased 24 points from her initial reading (64 to 88). Dr. Wilde suspected that she might have preeclampsia that day not only because of the high diastolic blood pressure, but because she still complained of headaches, edema, vomiting, nausea and had sustained a significant weight gain of 8 lbs in 3½ weeks. He described this "constellation" as "associated signs and symptoms of preeclampsia." Preeclampsia

is very dangerous because it may lead to eclampsia if untreated, resulting in high mortality and morbidity for both mother and fetus.

Dr. Wilde followed a rigid, bright-line standard for the diagnosis of preeclampsia: the patient must have both a blood pressure of 140/90 (systolic over diastolic) and protein in the urine. Otherwise, the patient does not have to be monitored or diagnosed with preeclampsia. Treatment does not have to be undertaken and the patient does not need to be warned. Dr. Wilde instructed Brenda to come back in two weeks. This was unsafe because the undisputed medical evidence indicates that a patient could have or be developing preeclampsia without proteinuria, and without a blood pressure of 140/90. The disease may fulminate into eclampsia, with convulsions or stroke, far more quickly than two weeks, possibly within hours or days, if untreated.

The tests for measuring blood pressure and detecting the presence of protein in the urine are simple, harmless, inexpensive, quick and highly reliable. They can be self-administered at home or on a repeat, next-day visit to the doctor's office, and may be performed by a nurse. Such means are readily available over-the-counter at pharmacies. The treatment for developing or mild preeclampsia is usually bed rest, or hospitalization if more serious, until the blood pressure decreases.

Dr. Wilde did not warn, instruct or advise Brenda that he initially suspected preeclampsia, or what symptoms to watch for during the two weeks. Brenda did not know that she was at risk. Dr. Wilde's standard of care is

dangerous to the public because it is not designed to pick up preeclampsia which either may be developing or may be present in a mild form (no proteinuria or blood pressure slightly under his "cut-off"). Serious injury can occur quickly. A two week return without warning or instruction to the patient is unsafe.

STATEMENT OF THE CASE

A. Nature of the Case and Proceedings Below.

This is an appeal from Amended Findings of Fact, Conclusions of Law and a Judgment entered on June 3, 1993, by the Honorable Michael R. Murphy, District Court Judge of the Third Judicial District Court. This case was tried to the bench beginning on September 22, 1992, and concluding on October 2, 1992. The court then requested post-trial memoranda dealing with "schools of thought" applicable to Dr. Wilde's treatment. The court took the matter under advisement for approximately 90 days. A Decision was issued orally on January 8, 1993. Thereafter, Findings of Fact and Conclusions of Law were submitted and challenged by the appellant. The final version of the Amended Findings of Fact, Conclusions of Law was issued on June 3, 1993.

B. Statement of Facts.

Preeclampsia is a serious hypertensive[1] disorder of pregnancy. It has been defined as follows: "*preeclampsia* is the development of hypertension with

[1] I.E., high blood pressure.

proteinuria, edema, or both, induced by pregnancy after the 20th week of gestation ...." Williams Obstetrics, 18th Ed., Cunningham, McDonald and Gant, Appleton & Lange, Norwalk Connecticut, 1989[2] (attached hereto as Appendix 1). If untreated, preeclampsia can develop into eclampsia[3], which is diagnosed when convulsions, not otherwise caused by any coincidental neurologic disease, develop in a woman who has clinical criteria for preeclampsia. Williams Obstetrics at 653. Eclampsia is a serious, life threatening medical condition which can involve seizures and a stroke-like condition in the mother and brain damage to an infant. Id. at 655, 672-3.

The incidence of preeclampsia nationally is about 5%, although it is higher in some populations. Id. at 656. Dr. Wilde's rate was 5%. Wilde T. 1250:19[4]. In general, eclampsia is preventable in the United States and has become less common because most women now receive good pre-natal care. Williams at 657; Wade T. 869:17-19. When properly diagnosed and treated, a pre-eclamptic woman may almost always avoid becoming eclamptic. Wade T. 869. Preeclampsia is almost exclusively a disease of women in their first pregnancy. Williams Obstetrics at 656; Wade T. 875:2.

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[2] This medical treatise was used extensively at trial by both sides. Dr. Wilde accepts it as authoritative. Wilde T. 1255-7.

[3] Sometimes called toxemia of pregnancy.

[4] Trial testimony is referenced as "T. ____," the record as "R.____" and trial exhibits as "Ex. ____." Important trial exhibits and medical articles used at trial are attached in the Appendix. The testimony of witnesses may be designated by their name, such as "Wilde T. _____." The page number is to the left of the colon; line numbers are to the right. Important testimony and deposition pages are included in the Appendix under the individual's name.

The plaintiff, Brenda Rivera was born January 26, 1964, and was 25 years of age at the time she consulted defendant for obstetrical care for her first pregnancy ("nullipara"). Ex. 1 p. 59-60 (attached with other pre-natal records as Appendices 2 and 3). Her first visit occurred on February 6, 1989. Ex. 1 p. 53, Appendix 2. Dr. Wilde determined her last menstrual period to have been December 10, 1988. On her last visit with Dr. Wilde on 6/15/89, she was recorded as 26 weeks pregnant, or at the very end of her second trimester. Ex. 1 p. 62, Appendix 3. On the general information form filled out for Dr. Wilde's office on February 6, 1989, Brenda Rivera revealed that her mother had "high blood pressure" and that her "sister had a stroke." Exhibit 1, p. 60, Appendix 2.

Dr. Wilde's chart records the following weights and blood pressure readings:

Date	Weeks	Weight	B.P. (Systolic/ Diastolic)[5]
3/1/89	11-1/2	157	98/64
4/24/89	19	170	110/72
5/22/89	24-5 [sic]	173	120/68
6/15/89	26	181	110/88

See Ex. 1, p. 62, attached as Appendix 3. During the last weeks of Brenda's pregnancy, two supervisors on the janitorial staff at the University of Utah Medical Center expressed their concern over Brenda's condition. They believed that she

[5] Systolic Blood Pressure is the maximum pressure on the walls of the arteries. It occurs near the end of the heart's contraction, or in other words, near the end of the ventricular systole. Diastolic Blood Pressure is the minimum pressure of the blood on the walls of the arteries. It occurs late in the period of the heart's expansion, or in other words during the ventricular diastole. Dorland's Illustrated Medical Dictionary, Philadelphia; W.B. Saunders Co., 27th ed. 1988.

had "toxemia" (preeclampsia) and that something was seriously wrong with her which was not being addressed by her doctor. Testimony of Pamela Sage (co-worker and supervisor) T. 1487:16-19, 1492:11-14; Linda Rogers (head supervisor) T. 1605:16-18. Among other concerns, these co-workers observed extreme swelling. Sage T. 1487:1-8, 1491:18-20; Rogers T. 1594:14-25, 1595:1-10.

Toward the middle of June, 1989, at approximately 26 weeks gestational age, Brenda Rivera was feeling very ill as a result of nausea, vomiting, headaches and swelling (edema). She was concerned by the comments of her co-workers to the effect that she might have toxemia. Wilde T. 1287. These problems were severe enough that her husband, Tony Rivera, called Dr. Wilde's office on June 12th to see if their appointment scheduled for June 15th could be moved to June 12th. Tony Rivera T.1343:5-18; Ex. 1, p. 62. No appointment was made, but Dr. Wilde's nurse, Sharon Kuehn, recorded her concern about possible preeclampsia in the doctor's chart on 6/12/89 as follows:

> Patient called. R/C [returned call] talked to Mr. [Tony Rivera], he states Brenda's feet and legs are swollen after being on them all day. She needs to elevate them plus increase water intake to come in Thursday. No other signs or symptoms of preeclampsia. If worsen, come in sooner.[6] (emphasis added)

Ex. 1, p. 62, Appendix 3. Thursday, June 15th was the last time that Brenda Rivera visited Dr. Wilde prior to the baby's birth on June 23, 1989.

On the June 15th visit, Tony Rivera accompanied Brenda to see Dr. Wilde. They waited in the air-conditioned office approximately one hour prior to

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[6] This is a translation of the words, signs and symbols in this record based upon the deposition of Dr. Wilde, p 149:12-16.

seeing Dr. Wilde because he was busy with a delivery. Tony Rivera T. 1349:11-19. When Brenda was taken into the examination room to see Dr. Wilde, her blood pressure was measured by his nurse at 110/88. This represented a 24 point jump in DBP (diastolic blood pressure) from Brenda's initial measurement in February, 1989. Dr. Wilde measured it again a few minutes later at 110/84, although this latter reading was not recorded in the chart[7]. Ex. 1, p. 62; Wilde T. 1279:9-10. Brenda's blood pressure was taken a third time by a nurse after she lay down on her left side (the other two readings were taken in the sitting position), and it measured 110/80. Wilde T. 45:12-17, 46:4-8. At the 6/15/89 visit, Brenda Rivera complained to Dr. Wilde, among other things, of:

a. Severe headaches (Wilde T. 1283:10-11) that did not resolve with Tylenol. Tony Rivera T. 1351.

b. Swelling of the face and hands. Wilde T. 1280:15-20; Tony Rivera T. 1353:4-19.

c. Nausea and vomiting. Wilde T. 1285:8-18.

Dr. Wilde accepts as authoritative in the field of obstetrics the book Williams Obstetrics, 18th Ed., Cunningham, MacDonald & Gant, Appleton & Lange, 1989. Chapter 35 entitled "Hypertensive Disorders in Pregnancy," attached as Appendix 1. Wilde T. 1255:22-25, 1256, 1257: 1-19. He is a member of the American College of Obstetricians and Gynecologists (ACOG), and subscribes to its journal. Wilde T. 1247:25, 1248. In February, 1986, ACOG published a

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[7] Dr. Wilde claims simply to "remember" taking this reading.

Technical Bulletin entitled "Management of Preeclampsia," attached hereto as Appendix 4. The Bulletin was established as authoritative by plaintiff's expert, Maclyn Wade, M.D. Wade T. 857:1-6.[8] Dr. Wilde claims to disagree with this standard for diagnosing preeclampsia. Wilde T. 1296-8.

On the 6/15/89 visit, Dr. Wilde suspected that Brenda Rivera had preeclampsia when he entered the examination room. Wilde T. 1298:18-25; see also Wilde depo. 168-9; 170:1-3. Dr. Wilde stated:

> Q. Why did it raise a specter of preeclampsia to you?
>
> A. Why?
>
> Q. What was it about what happened on the 15th of June that raised a specter of preeclampsia?
>
> A. Again, the constellation of associated symptoms would suggest that I diligently look for hypertension and proteinuria and that continued vigilance ensue.
>
> . . .
>
> Q. As you went in that day did you have on your mind the fact that this woman, Brenda Rivera, might have preeclampsia?
>
> A. Yes. (emphasis added)

Wilde depo, 169:8-16,25 - 170:1-3, as read at trial, Wilde T. 1297-8, 1298:18-25. He further testified:

> Q. Okay. p. 170: "Doctor that day when you opened the door, you suspected that she had preeclampsia, didn't you?" (Reading the question from deposition)
>
> A. I have testified to that.

---

[8] At trial, in order to save time, the parties stipulated that the court could receive a notebook of medical articles to review on its own. This document was in that notebook. Wade T. 849-50.

Q. Okay. You suspected it because in your own words Brenda Rivera had a constellation of symptoms; isn't that right?

A. Correct.

Q. And those signs and symptoms form that constellation you were referring to on page 169 [of your deposition], that constellation was nausea, vomiting, headaches, edema and a blood pressure spike of 24 points and a diastolic blood pressure of 88. Isn't it true that that was a constellation you were referring to?

A. Correct. (emphasis added)

Wilde T. 1298-9.

Brenda Rivera's diastolic blood pressure of 88 mmHg (i.e., millimeters of mercury) on 6/15/89 had raised in Dr. Wilde's mind the "clinical suspicion" of preeclampsia. Wilde T. 1298:18-25-1299:3; 1313:7-12.[9] A diastolic blood pressure of 88 can be an "associated sign" of preeclampsia. Wilde T. 1298:18-25; see also Wilde depo. 165:12-18. Diastolic is more important than systolic in looking at preeclampsia. Wilde T. 1254:3-4; Wade T. 1057:3-6.

Dr. Wilde admitted the duty to watch carefully for preeclampsia, particularly because of some of the symptoms that Brenda exhibited or complained of:

Q. ... "Question: What was it about what happened on the 15th of June that raised a spectre of preeclampsia?" Please read that answer, doctor."

[9] Q. Well, but it [the diastolic blood pressure] was high enough to raise the specter of possible pre-eclampsia, wasn't it? A. It would raise your clinical suspicion. Q. So, that blood pressure reading, particularly 88, was the one that -- the 88 reading did in fact raise your clinical suspicion on this day that she might have pre-eclampsia? A. Correct. (emphasis added) Wilde depo. 173:16-23.

A. "Again: the constellation of associated symptoms would suggest that I diligently look for hypertension and proteinuria, and the continued vigilance ensue." (emphasis added)

Wilde T. 1297:23-1298:6 (reading his deposition).

At the 6/15/89 visit, Brenda Rivera complained of having headaches, edema and of being very nauseous with continued vomiting which are part of Dr. Wilde's "constellation of symptoms." Wilde T. 1285:8-18; 1298:18-25; 1299:1-3). Brenda Rivera complained specifically to Dr. Wilde of facial edema (Wilde T. 1280:21-25, 1280:1-14), as well as "persistent edema." Wilde T. 1279:15-20. Dr. Wilde was particularly concerned about the complaints of abnormal swelling of the face. Wilde T. 1280:16-25.

Rapid weight gain is one of the constellation of signs and symptoms of preeclampsia. Wilde T. 1297:2 - 1298:1-5. Brenda Rivera had a sudden weight gain (8 lbs in 3½ weeks) and this can be a sign of possible preeclampsia. Farnsworth T. 1140:22-23; Wilde T. 1297:2 - 1298:5.

Unrelenting headaches of increasing intensity between the second and third trimester are sometimes a sign associated with preeclampsia. Wilde T. 1296:25, 1297, 1298:1-5; see also Wilde depo. 180:10-14. Brenda Rivera complained to Dr. Wilde on 6/15/89 of "very bad headaches." Wilde T. 1283:11; Tony Rivera T. 1351:5-18. Dr. Wilde admits he told the Riveras that her headaches should be going away in the context of advising Brenda and Tony that her abnormalities at present could be explained as "this flu-like syndrome." Wilde T. 1288:11-22.

Brenda had no proteinuria on 6/15/89. Wilde T. 1287:20-25, 1288:1-3. Proteinuria is a sign of preeclampsia; however, proteinuria in early preeclampsia may be minimal or entirely lacking. Farnsworth T. 1162:12-13, 1164:6-9; see also Wilde depo. 199:15-18.

Regarding treatment of possible mild preeclampsia, Dr. Wilde stated:

> A. ... And you observe the patient until you have determined whether she has a normal blood pressure or not. If she does not have a normal blood pressure, then she would be brought back the next day to have her blood pressure checked or, depending on its level, she may be admitted directly to the hospital. (emphasis added)

Wilde T. 1255:3. Dr. Wilde did not give Brenda Rivera warnings or oral instructions about possible preeclampsia. He did not advise bed rest, but told Brenda she could go back to work as a janitor with some restrictions such as elevating her feet when she gets home and taking breaks at work. Wilde T. 1291:17-25, 1292:1-9. None of Brenda Rivera's actions caused her to develop preeclampsia or eclampsia. Farnsworth T. 1182-3.

At the time of the baby's birth, Brenda was approximately 27-1/2 weeks and the baby was, therefore, approximately 12 weeks premature. Brenda was found the morning of June 23rd in a coma and life-flighted to University Hospital for delivery. Ex. 1, pps. 71-73. Her diagnosis was eclampsia. Id. Brenda Rivera's preeclampsia fulminated (or developed) into full blown eclampsia on or before 6/23/89, at which time she suffered "hemorrhagic cerebellar infarction." Ex. 1, p.148, 92.

POINT I

INSUFFICIENT EVIDENCE TO ESTABLISH SAFE STANDARD.

There is insufficient evidence to establish that Dr. Wilde followed a safe standard of care in failing to diagnose developing or existing preeclampsia. Dr. Wilde followed a rigid, bright-line standard for the diagnosis of the dangerous condition, which required blood pressure of 140/90 plus proteinuria. He rescheduled his next appointment with plaintiff for two weeks. The undisputed evidence shows a significant number of patients, however, will develop or have mild preeclampsia and even eclampsia without ever meeting Dr. Wilde's rigid criteria. Therefore, the trial court's finding that Dr. Wilde's standard was safe was clearly erroneous and against the clear weight of the evidence.

A. Legal Standard.

The Utah Supreme Court has held:

> To mount a successful challenge to the correctness of a trial court's Findings of Fact, appellant must first marshal all the evidence supporting the finding and then demonstrate that the evidence is legally insufficient to support the findings even in viewing it in the light most favorable to the court below. ... The legal sufficiency of the evidence is determined by the ... "clearly erroneous" standard.... A finding attacked as lacking adequate evidentiary support is deemed "clearly erroneous" only if we conclude that the finding is against the clear weight of the evidence.

Reid v. Mutual of Omaha, 776 P.2d 896, 899 (Utah 1989). The failure to enter adequate findings of fact on material issues may be reversible error. Id. A finding may be deemed clearly erroneous either if it is without "adequate evidentiary support or induced by an erroneous view of the law." T.R.F. v. Felan, 760 P.2d 906 at 909 (Utah App. 1988), quoting Wright & Miller, *Federal Practice & Procedure*, §2585, p. 193 (1971).

B. Dr. Wilde's Standard and the Trial Court's Findings.

Plaintiff challenges primarily Finding of Fact Nos. 10, 11, 12 and 14. See Appendix 12. In Finding No. 10, the court finds:

> Based upon the expert testimony and medical literature presented, the court finds that defendant's treatment of the plaintiff complied with an acceptable school of thought which is within the standard of care. It was appropriate for defendant to adopt and adhere to the school of thought that: (1) defines preeclampsia as a blood pressure of equal to or greater than 140/90 and the presence of proteinuria and (2) considers edema (even of the face and hands) and weight gain as so common in pregnancy that they are useless for the diagnosis of preeclampsia. (emphasis added)

Finding 11 states that plaintiff has not demonstrated by a preponderance of the evidence that the school of thought that the defendant followed is unaccepted, insufficient or "unsafe." Findings 12 and 14 are simply an elaboration of reasons for the Findings 10 and 11 that Dr. Wilde followed an "accepted," "safe" school of thought.

Finding 10 shows that Dr. Wilde followed a bright-line standard for the diagnosis of developing or existing preeclampsia. Unless the patient has a blood pressure of 140/90 with proteinuria, developing or existing preeclampsia is ruled out and no follow-up or treatment is warranted. Period! Because Brenda Rivera did not meet that criteria, she wasn't treated by Dr. Wilde on June 15, 1989, and in fact she was instructed not to return for two weeks (instead of one or two days for a recheck). Accordingly, Finding 6 states:

> Defendant asked plaintiff to come back for another pre-natal visit in two weeks, rather than the regular interval of one month. ... During this office visit [6-15-89], the defendant considered the possibility of preeclampsia and upon examination and evaluation ruled out the

> diagnosis of preeclampsia in accordance with the accepted school of thought to which he adhered. (emphasis added)

At trial, Dr. Wilde clearly stated that he could "wait" until the patient met these criteria before initiating treatment. Wilde T. 1312:8-17. The following colloquy is an example:

> Q. ... Well, you testified, did you not, earlier, that 24 diastolic point increase was dangerous, in your opinion? You used the word dangerous in your terms? It would raise concern. It did, in fact, raise your concern, didn't it?
>
> A. It did.
>
> Q. It did. Now, is there a school of thought that says that an obstetrician doesn't have to treat a dangerous increase in diastolic blood pressure? Just say it hasn't hit 90. That's the question.
>
> A. I can't answer that with a yes or no. I will not.
>
> Q. You can't answer it with a yes or no, or you will not? Okay. Is there a school of thought that says that if in a patient like Brenda Rivera that the signs and symptoms -- with the signs and symptoms you were concerned with on 6-15, that you let that patient wait for proteinuria to develop before you initiate treatment. Is there such a school of thought? And if so, I don't know where it is in the literature. Can you show me?
>
> A. The answer is yes. The majority opinion is they do not have preeclampsia until they have a persistent elevation in blood pressure, as I have previously stated, and that they have proteinuria. And if they do not have the diagnosis, they do no need to be treated. You do not treat people for diagnoses that do not exist. (emphasis added)

Wilde T. 1313:7 - 1314:9. Elsewhere, Dr. Wilde admitted in his deposition, read at trial, that his clinical cut-off is a blood pressure of 140/90 and proteinuria. Wilde T. 1299:25 - 1300:7; 1301:24 - 1302:14; 1311:7-10 ("certain cut-off points").

Dr. Wilde's obstetrician expert, Kent Farnsworth, M.D. likewise testified:

> Q. ... What I am saying is, it would -- would it fall below the standard of care if an obstetrician like Dr. Wilde had a rigid definition of preeclampsia, 140/90, proteinuria, and made no exceptions? In other words, he would not diagnose or treat a patient until she had 140/90 and proteinuria?
>
> A. I would answer that question by saying that in your practice you have to have some cutoffs. You're seeing a large number of patients in your office every day and you have to have areas where you take action and areas where you don't. And 140/90 and proteinuria is the area where you take action. I don't see you taking action prior to meeting those criteria as far as, you know, taking major action with a patient, if that is what you are asking. ...
>
> Q. Your telling me that, then, if you had a rigid standard that you have to have 140/90, and both 140/90 and proteinuria, if you don't diagnose or treat until they hit these criteria, that's within the standard of care?
>
> A. Yes, that's right. (emphasis added)

Farnsworth T. 1155:16 - 1156:15. Dr. Farnsworth defended the possibility that certain patients with preeclampsia would be missed rationalizing the clinical problems of a large number of patients and a large practice:

> Q. But now if you have a rigid standard, and you require, for example, proteinuria to be present, and a certain number of patients develop eclampsia, without ever having proteinuria, then wouldn't that standard miss those patients?
>
> A. Again, I think the issue here is a clinical setting of trying to triage a large number of patients. Where we talked about earlier is trying to balance over-diagnosing and under-diagnosing in a practice where you are seeing a large number of patients, and you are trying to provide treatment in those conditions, I think it is reasonable. There's no question that some texts will tell you that some of the people can have preeclampsia without having proteinuria. In a

practice where you are seeing large groups of patients, I think this is a very reasonable standard. (emphasis added)

Farnsworth T. 1157:1-17.

C. Marshaling of Evidence Supporting the Trial Court's Finding.

The following evidence, stated from defendant's point of view, supports the challenged Findings of Fact as "not unsafe":[10]

1. Accepted, Majority Standard of Care. Dr. Wilde's standard that no diagnosis, treatment or follow-up for developing or existing preeclampsia is warranted until and unless the plaintiff meets the rigid standard of blood pressure of 140/90 plus proteinuria, is supported by a majority of respected physicians in this medical community and others, nationally and outside the state of Utah. This standard is not only theoretical, but in clinical use by a large number of physicians. Wilde T. 1255; Farnsworth T. 1116:11-25 - 1117:1-4.

2. Practical Necessity of Clinical Practice. A bright-line, rigid cut-off point is acceptable and even necessary because of the large number of patients that a practicing obstetrician must deal with on a day-to-day and weekly basis. This standard is easy to administer. Plaintiff's suggested standard of diagnosing preeclampsia if the diastolic blood pressure increases by more than 15 mmHg in the presence of generalized edema (hands and face), with or without the other constellation of associated signs and symptoms, is too broad. It would mean

[10] Plaintiff hastens to point out that she does not agree that these points are sustainable or well-taken. However, the requirement is to marshal the evidence in a manner most favorable to the verdict and the above statements represent the most favorable manner in which the evidence could be construed as supporting the errant Findings of Fact.

classifying large numbers of normal women as pre-eclamptic. It would lead to over-diagnosing the condition based upon factors that are too common in normal pregnancy to be of any clinical value. Wilde T. 1293-4; Farnsworth T. 1117.

3. Authoritative Literature Supports Dr. Wilde. The learned literature on the subject shows at least two widely accepted schools of thought on when to define, diagnose and treat developing and existing preeclampsia. The standard followed by Dr. Wilde is one of the standards (even the majority standard) set forth in the literature. A large number of respected obstetricians writing on the subject agree that Dr. Wilde's standard is the appropriate clinical standard. Wilde T. 1270,1309, 1321; Farnsworth T. 1159-60.

4. Plaintiff's Suggested Signs and Symptoms Are Unreliable. There is no correlation between edema, headaches, vomiting, nausea, weight gain, a greater than 15 mmHg increase in diastolic blood pressure and preeclampsia. These vague criteria have little or no clinical significance because they are so common. This is supported by the clinical experience of Drs. Wilde and Farnsworth (Farnsworth T. 1118 - 1120:1-15), a respected, accepted viewpoint of the majority in the medical community and a large body of authoritative literature on the subject. Wilde T. 1256 - 1260:1-20, 1320, 21.

5. Eclampsia Always a Risk. A patient can develop eclampsia even though she has the best of obstetric care. Wilde T. 1253; Farnsworth T. 1116:3-10; 1128:8-17.

6. Careful Exam Ruled Out Preeclampsia. Dr. Wilde conducted a careful and thorough evaluation of Brenda Rivera on 6/15/89. He considered every aspect of the constellation of associated signs and symptoms of preeclampsia, including her complaints of headaches, nausea, vomiting and edema, as well as evaluating her 8 lb weight increase and 24 mmHg spike in DBP. He ruled out each one of these conditions as being induced by preeclampsia because she did not have 140/90 and did not have proteinuria. There was therefore no need to diagnose or treat her as pre-eclamptic. Wilde T. 1313:7 - 1314:9; Farnsworth T. 1155-6.

D. Evidence Legally Insufficient to Support Findings.

The following evidence, largely undisputed, demonstrates the lack of the evidentiary support and the clearly erroneous nature of the finding that Dr. Wilde's standard was acceptable and safe:

1. Introduction. The evidence, even viewed in a light most favorable to the court below, is legally insufficient to support Findings 10, 11, 12 and 14 insofar as they find that Dr. Wilde's standard was an acceptable, "safe" school of thought. These findings are clearly erroneous, not only because they lack evidentiary support when the undisputed evidence is viewed fairly, but the findings are based upon an erroneous view of the law. Implicit in the court's findings is that Dr. Wilde's standard is "safe" because it is accepted by a majority of the doctors in this and other medical communities. However, the clear weight of the evidence is that Dr. Wilde's standard is unsafe because it fails to sufficiently monitor and treat patients who are either developing or have a mild case of existing preeclampsia.

Such individuals can fulminate into full-blown eclampsia prior to two weeks; thus, Dr. Wilde's standard is unsafe for a great many women in Utah.

At the outset of this discussion, a preliminary statement needs to be made. Dr. Wilde and Dr. Farnsworth both testified that the standard of care allowed them to delay diagnosis and treatment of developing or existing preeclampsia until the patient's blood pressure reached 140/90 and the patient had proteinuria. Since there was evidence of that standard, and the findings adopted it, plaintiff is constrained to accept it as an existing school of thought for purposes of this appeal. Under that standard, Dr. Wilde can send a patient away for two weeks even though her blood pressure is 139/89 and she is one hour away from developing proteinuria. Plaintiff merely wishes to emphasize that although there is testimony in the record of such a standard, plaintiff believes that in reality, no such standard actually exists. Based upon his own patient charts which Dr. Wilde introduced into evidence, plaintiff doubts that Dr. Wilde himself consciously follows such a standard. Wilde T. 1317-19. Dr. Wilde's "standard" was really an afterthought concocted to justify negligent oversight on this case. In the words of Justice Ellett, it "beggars the imagination" to think that a doctor, viewing a patient with a progressive, dangerous and sometimes insidious condition such as preeclampsia, would wait two weeks to see if the patient meets a bright-line standard before initiating treatment, without monitoring to see where the condition goes during the two weeks. Nevertheless, because there is evidence of that

standard, plaintiff addresses it as though it is actually the standard followed by Dr. Wilde in this case.

2. Importance of This Issue for Women of Utah. The resolution of this issue by the Court of Appeals is very important for the women of Utah because it sets the standard of care in this community for the recognition and treatment of preeclampsia. Evidence at trial was that Dr. Wilde observed preeclampsia in his patients at the rate of 5% (Wilde T. 1250), and that Dr. Wade thought the rate to be about 5-8% based upon the literature.[11] Wade T. 897. Utah's Vital Statistics Summary, published by the Utah Department of Health, reveals that there were 36,253 live births in Utah in 1990 and 36,016 in 1991. See Appendix 5. Five to eight percent means that there are possibly 1812 to 2900 cases of preeclampsia in the State of Utah every year, if other doctors have similar rates. Dr. Wilde testified that he has delivered about 175 patients per year for the past 9 years and 5% of that total would be 78 patients with preeclampsia. Wilde T. 1250. Accordingly, any standard of care which needlessly subjects these patients to a higher risk of developing eclampsia should be rejected by this court.

3. Goal is Early Recognition of Condition. The parties agree that a primary goal in dealing with eclampsia is early recognition of the condition, either developing or existing, and there is no school of thought that says that "late

[11] The article referred to by Dr. Wade indicates an 8% rate, but the rate is higher among black populations and those in lower socio-economic groups which probably accounts for Utah's lower rate.

detection of preeclampsia is better than early detection." Wilde T. 1315:19. Relying upon an authoritative text, Dr. Wade testified as follows:

> "At present, clinical management is dictated by the overt clinical signs of preeclampsia. Unfortunately, proteinuria -- the most valid clinical indicator of preeclampsia -- is often a late change, sometimes even preceded by seizures, and so is not a useful sign for early recognition. Although rapid weight increase and hand and face edema indicate the fluid and sodium retention characteristic of preeclampsia, they are neither universally present nor uniquely characteristic of preeclampsia.
>
> These these (sic) signs are, at most, a reason for closer observation of blood pressure and monitoring of urinary protein. Early recognition of preeclampsia is based primarily on diagnostic blood pressure increases in the late second and early third trimesters in relation to early pregnancy.
>
> Using blood pressure changes without evidence of proteinuria as an indicator does, undoubtedly, result in the diagnosis of preeclampsia in some normal women as well as in some with underlying renal or vascular disease. But the goal of early diagnosis is to identify patients requiring more careful observation. However, overdiagnosis is preferable to underdiagnosis." (emphasis added) Quoting Creasey & Resnik, Maternal-Fetal Medicine, W. B. Saunders Company, 2nd Ed. 1989, p. 804, No. 38.

Wade T. 989:3-25. This article was cited frequently and is therefore attached hereto as Appendix 6, for easy reference.

4. A Court Need Not Accept an Unsafe Standard. Even though a standard of care may be practiced by a majority of physicians in a given community, and may represent a "school of thought," this court need not accept it. The trial court's view of the evidence was influenced or induced by the erroneous view of the law that because Dr. Wilde's standard of care was followed by other

members of the medical community, and advocated in some of the learned literature, it was somehow, therefore, safe.

The court may reject any unsafe standard, no matter how widespread it is in the community. In Swan v. Lamb, 584 P.2d 814 (Utah 1978), an orthopedic surgeon performed a lumbar decompression laminectomy, leaving pantopaque in the surgical area which caused inflammation and injury to nerve roots and rendered plaintiff paraplegic. Defense experts testified that the local custom was to leave the dye in the body.[12] Justice Ellett phrased the issue as "whether or not the local doctors know better and, therefore, do not have to be as good as doctors in other areas of the country . . ." Swan held:

> There is no need for doctors here to have a lower standard of care than other doctors who are practicing in similar localities. Indeed, it is doubtful that any physician in the State of Utah would be willing to admit that his skill and knowledge is not equal to any other physician trained in his field, or that his ability is less than that of doctors trained and practicing in other cities. . . . If surgeons throughout the nation consider it improper to allow foreign substances that have been injected into the spinal canal to remain there after completing a myelogram, it beggars the imagination to think a doctor in Salt Lake City could escape responsibility for harm done to his patient by failing to remove the substance merely because the local custom is to leave the substance in the canal so that it will be absorbed by the body. If this procedure is generally regarded to be unsatisfactory or dangerous, no doctor should escape responsibility merely because the local practice has not yet adopted it. (emphasis added)

Id. at 817, 818.

[12] This case involved the "local standard" rule which was overturned. The language justifying the decision seems applicable here, even though the legal issue is different.

Helling v. Carey, 529 P.2d 981 (Wash. 1974), Appendix 7, is a case amazingly similar to Rivera. An ophthalmologist failed to diagnose glaucoma in a 32 year old patient. During the trial, uncontradicted testimony from medical experts for both plaintiff and defendant established that the standards of the profession did not require routine pressure tests for glaucoma upon patients under 40 years of age because the disease rarely occurs in this age group. Id. at 982. "Testimony indicated, however, that the standards of the profession do require pressure tests if the patient's complaints and symptoms reveal to the physician that glaucoma should be suspected." (emphasis added) Id. The evidence indicated a pressure test for glaucoma was very simple, inexpensive, highly confirmatory, harmless and could have been timely given in this case. Id. The court observed:

> The incidence in glaucoma in one out of 25,000 persons under the age of 40 may appear quite minimal.[13] However, that one person, the plaintiff in this instance, is entitled to the same protection, as afforded persons over 40, essential for timely detection of the evidence of glaucoma where it can be arrested to avoid the grave and devastating result of this disease.

Id. The defendants claimed that the community standard should bind the court; the court quoted Judge Learned Hand in response:

> "[I]n most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission." (emphasis added in Helling) The T. J. Hooper, 660 F.2d 737, 740 (2nd Cir. 1932)

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[13] This was the undisputed medical evidence at trial.

As cited in Helling, 519 P.2d 983. Helling therefore held:

> Under the facts of this case reasonable prudence required the timely giving of the pressure test to this plaintiff. A precaution of giving this test to detect the incidence of glaucoma to patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the ophthalmology profession, it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma. We therefore hold, as a matter of law, that the reasonable standard that should have been followed under the undisputed facts of this case was the timely giving of the simple, harmless pressure test to this plaintiff and that, in failing to do so, the defendants were negligent, which proximately resulted in the blindness sustained by the plaintiff for which the defendants are liable. (emphasis added)

Helling at 983.[14]

In United Blood Services v. Quintana, 827 P.2d 509 (Colo. 1992), plaintiff contracted AIDS after having received a transfusion of tainted blood. The undisputed evidence showed that defendant had followed the industry's standard of care. It was reversible error for the trial court to exclude proffered testimony by plaintiff's experts that screening and testing procedures used by the entire blood bank industry were substandard and unreasonably deficient. Id. at 525.[15] The court then explained that if plaintiff establishes that the:

> ... professional standard of care adopted by the school of practice to which the defendant adheres is unreasonably lacking in readily available safeguards offering substantially more protection against the

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[14] Despite a later statute change, the Washington Supreme Court nonetheless has upheld Helling in Gates v. Jensen, 595 P.2d 919 (Wash. 1979).

[15] The court explained: "If the standard adopted by a practicing profession were to be deemed conclusive proof of due care, the profession itself would be permitted to set the measure of its own legal liability, even though that measure might be far below a level of care readily attainable through the adoption of practices and procedures substantially more effective in protecting others against harm than the self-decreed standard of the profession." Id. at 520.

> harm caused to the plaintiff, the issue of whether the standard of care adopted by the defendant's school constitutes due care is a question for the jury to resolve under appropriate instruction. (emphasis added)

Id. United Blood Services contains an excellent survey of cases from many jurisdictions that the court may reject an unsafe standard of care. Id. at 525-6. Counsel is aware of no case standing for the contrary. By way of a sampling, the Supreme Court of Wyoming has held:

> The skill, diligence, knowledge, means and methods are not those "ordinarily" or "generally" or "customarily" exercised or applied, but are those that are "reasonably" exercised or applied. Negligence cannot be excused on the grounds that others practice the same kind of negligence. Medicine is not an exact science and proper practice cannot be gauged by a fixed rule. (emphasis added)

Vassos v. Roussalis, 625 P.2d 768, 772 (Wyo. 1981).[16] See also Morgan v. Sheppard, 188 N.E.2d 808, 816 (Ohio App. 1963).[17]

This Court is choosing a standard for the safe treatment of Utah women who may be developing or have preeclampsia. It is important that the standard be safe. The standard proposed by plaintiff of monitoring plaintiff's blood pressure and protein when confronted by a constellation of signs and symptoms of preeclampsia is easy, harmless, inexpensive, not unduly burdensome for doctors, reliable and common sense-oriented. Above all - it's safe!

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[16] Reaffirmed in a second appeal at 658 P.2d 1284 (Wyo. 1983).

[17] Other cases in accord: Lundahl v. Rockford Memorial Hospital Association, 235 N.E.2d 671, 674 (Ill. App. 1968) ("It is entirely possible . . . that what is the usual or customary procedure might itself be negligence."); Toth v Community Hospital at Glen Cove, 239 N.E.2d 368, 375 (N.Y. App. 1968) (physician not automatically freed from liability because he adhered to "acceptable practice"); and Darling v. Charleston Community Memorial Hospital, 211 N.E.2d 253, 257 (Ill. 1965) ("custom should never be conclusive").

5. **Unsafe to Wait for Proteinuria.** Dr. Wilde's rigid, bright-line standard for diagnosing developing or existing preeclampsia requires the presence of proteinuria before the doctor takes any action. In other words, there is no need to schedule more frequent visits, repeat testing, explain the condition to the patient, warn the patient or anything else unless and until the patient has both 140/90 and proteinuria. Wilde T. 1313-4. However, the evidence was undisputed that many women develop both preeclampsia and eclampsia without ever having had proteinuria. This evidence was never challenged or disputed by Dr. Wilde at trial! It was admitted by Dr. Farnsworth. Farnsworth T. 1160-1. Obviously, if Dr. Wilde is waiting for proteinuria to develop in a preeclamptic patient who may never develop it, there is a realistic chance that the patient will develop eclampsia, with all of the risks of maternal and fetal death and morbidity, before Dr. Wilde ever acts. That standard is unsafe and should not be countenanced by this court and should not be the policy of the State of Utah.

Plaintiff introduced significant evidence through Dr. Wade, quoting extensively from learned, authoritative texts, to the effect that preeclampsia and eclampsia may develop without proteinuria. The section quoted In Point I.D.3 above from Creasey & Resnik indicates that although "proteinuria is the most valid clinical indicator of preeclampsia," it is often a "late change" and is therefore "not a useful sign for early recognition." Dr. Wade further read this quote from Creasey & Resnik:

> "In spite of the specificity and fetal prognostic significance of proteinuria, however, we must emphasize that eclampsia can recur (sic - occur) without proteinuria."

Wade T. 974:7 (quoting Maternal-Fetal Medicine, p. 782, Appendix 6). Dr. Wade also noted for the court a significant study in an article by Villar and Sabai establishing that the presence of proteinuria is not necessary for the diagnosis of eclampsia, as just over 20% of eclamptic patients do not have proteinuria. Wade T. 974:13 - 975:2. Portions of this article are attached as Appendix 8.

Dr. Wilde read extensively at trial from Williams Obstetrics on the subject of proteinuria, to the effect that proteinuria is an important sign of preeclampsia and the diagnosis is "questionable" in its absence. Wilde T. 1258:9-11; Appendix 1, p. 654, right-hand column. However, Dr. Wilde stopped reading one sentence before the following quote:

> The degree of proteinuria may fluctuate wildly over any 24-hour period, even in severe cases. Therefore, a single random sample may fail to detect significant proteinuria.

Id. Additionally, Dr. Wilde never did read, nor otherwise address, additional quotes from the same chapter necessary for context, that stand unrefuted by the defendant. Dr. Wade, read into the record language from the same discussion on proteinuria omitted by Dr. Wilde (on the next page):

> "When the blood pressure rises appreciably during the later half of pregnancy, it is dangerous, to the fetus especially, not to take action simply because proteinuria has not yet developed. As Chesley (1985) emphasizes, 10% of eclamptic seizures develop before overt proteinuria." (emphasis added)

Wade T. 915:19; Appendix 1, p. 655 - left side of page. Additionally, later in that same chapter under the subheading "Clinical Aspects of Preeclampsia," Dr. Wade read the following section on proteinuria:

> "The degree of proteinuria varies greatly in preeclampsia, not only from case to case, but also in the same woman from hour to hour. The variability points to a functional (vasospasm) rather than an organic cause. In early preeclampsia, proteinuria may be minimal or entirely lacking. ... Proteinuria almost always develops later than hypertension and usually later than excessive weight gain." (emphasis added).

Wade T. 972:11; Appendix 1, p. 672.

At trial and/or deposition, Drs. Wilde and Farnsworth both agreed that a woman may be pre-eclamptic and even eclamptic without ever having demonstrated proteinuria!! Dr. Farnsworth testified:

> Q. (By Mr. Sykes) "Is it your belief that in order to have a diagnosis of preeclampsia you must have proteinuria?" Your answer: "That's a hard question to answer, I can think of clinical situations where in the mild form of preeclampsia, you will not have proteinuria." You did answer that way, didn't you?
>
> A. Yes. (emphasis added)

Farnsworth T. 1160 - 1161:2[18] The court requested that plaintiff's counsel limit his cross-examination of Dr. Wilde due to time constraints. Wilde T. 1295:8-12. As a result, significant portions of cross-examination of Dr. Wilde were omitted. However, it is clear that Dr. Wilde did in fact admit at his deposition, when he read

[18] Additional sections of Dr. Farnsworth's testimony at trial were also read and are found at Farnsworth T. 1162-3. In that additional deposition testimony, Dr. Farnsworth indicates that despite the fact that you can have pre-eclampsia without proteinuria, in his practice, he is still going to look to hypertension plus proteinuria to determine how to treat the patient. Farnsworth T. 1162:23-25.

the above Williams quote, that proteinuria may be minimal or entirely lacking in early preeclampsia:

> Q. Paragraph 10, right in the middle, says, "In early preeclampsia, proteinuria may be minimal or entirely lacking." Do you agree with that?
>
> A. I agree.
>
> Q. I thought you told me earlier that proteinuria must be present to have preeclampsia.
>
> A. Correct.
>
> Q. Well, this says that proteinuria does not have to be present, it may be minimal or entirely lacking in early preeclampsia.
>
> MR. WILLIAMS: You are misquoting or quoting out of context, this text clearly identifies the criteria for making a diagnosis.
>
> Q. (By Mr. Sykes) Go ahead and answer the question. It says, "In early preeclampsia, proteinuria may be minimal or entirely lacking."
>
> A. I don't know what early preeclampsia is.

Wilde Depo. 199:19 - 200:6, attached hereto as Appendix 9.

Dr. Wilde's trial evidence never even addressed the possibility of preeclampsia or eclampsia without the presence of proteinuria. It was not denied or explained by either Dr. Farnsworth or Dr. Wilde at trial. Various passages of literature quoted by Dr. Wade sustain the view, universally accepted by virtually all obstetricians, that a significant number of women have preeclampsia and eclampsia without ever having proteinuria. Dr. Wade's opinion on the subject, which amounts to reading the learned literature (Williams Obstetrics) and affirming his agreement

therewith, therefore stands unrebutted and unchallenged. This evidence must therefore be taken as admitted.

This evidence has grave safety implications for Utah women. Dr. Wilde's evidence and testimony reiterated over and over is that he specifically took no action in Brenda Rivera's case because she had no proteinuria. In other words, he took no action, because something wasn't present that is either "minimal or entirely lacking" in early preeclampsia, or isn't even found in many women who are eclamptic. According to Williams, it is "dangerous" not to take action in the face of a rising blood pressure, just because proteinuria has not yet developed. That is plaintiff's point exactly. Some action was required by Dr. Wilde in the face of a diastolic blood pressure just shy of his own 90 cut-off. For all Dr. Wilde knew, Brenda could have been one hour, one day or maybe two days away from a positive protein reading. When she was admitted on June 23rd at University Hospital, her blood pressure and protein readings were out-of-sight,[19] so she obviously developed proteinuria sometime between June 15th and June 23rd.

Brenda's eclamptic seizures and stroke-like condition are proof positive of the unsafe standard. On June 15, Dr. Wilde scheduled Brenda's next appointment for two weeks because she didn't have protein in the urine or blood pressure of 140/90. What he should have done was watch her more closely to see if her blood pressure stayed high or see if she developed proteinuria. Instead of

[19] See the University of Utah admission records, Exhibit 1: 91. These show a protein reading of: 4+.

making provision to have Brenda tested again, Dr. Wilde sent her home, and allowed her to continue working. She had seizures eight days later.

Dr. Wilde's standard is simply unsafe and shouldn't be accepted by this court regardless of the number of physicians that follow it.

6. A 140/90 Blood Pressure Cut-off is Unsafe. Drs. Wilde and Farnsworth stated unequivocally that a patient's blood pressure must reach 140/90 (both 140 systolic and 90 diastolic) before she is diagnosed and treated as pre-eclamptic. See Point I.B above. Any blood pressure measurement even a little less than 140/90 would not meet the rigid cut-off criteria and no action would be taken. Farnsworth T. 1172:5-19[20]; Wilde T. 1312:8-17. This is unsafe because hypertension can be "relative," depending upon the person. Dr. Wade, again quoting from a learned treatise by well-known obstetricians Villar and Sabai, noted:

> A. "Hypertension is the hallmark of eclampsia. This can be severe, above 160 millimeters of mercury systolic, or above 110 millimeters of mercury diastolic, as shown in 42.6 percent of our severe is, or mild 140 to 160 millimeters of mercury systolic, or 90 to 110 millimeters of mercury diastolic, seen in 20.4 percent.
>
> Q. Let me stop you there at that point, it's talking go [sic] about eclampsia, is he not?
>
> A. Yes.
>
> Q. Continue reading that quote, please?
>
> A. "In some cases the hypertension is relative, 120 over 80 millimeters of mercury. In this situation hypertension is signified by

[20] Dr. Farnsworth was asked if Brenda had 1+ proteinuria and 140/89, would he treat her or "watch her more closely." He said that you have to have some "control system" in a clinical practice, so "no, I probably would not" treat her. Farnsworth T. 1172:18. He would treat her, however, if her diastolic blood pressure was 2 points higher, 141/91. Farnsworth T. 1172:17.

> any rise in blood pressure that's 30 millimeters of mercury systolic, or 15 millimeters of mercury diastolic above the mid-trimester blood pressure readings. Most young primavaras [sic - primagravidas] have initial diastolic between 50 an 60 millimeters of mercury during the second and early third trimester of pregnancy. Consequently, some of these patients may suffer convulsions with relative degrees of hypertension." (emphasis added)

Wade T. 905:19 - 906:14, quoting Villar and Sabai, supra, page 358, Appendix 8. Dr. Wade's testimony in this regard stands unrefuted. Although Drs. Wilde and Farnsworth strongly adhere to the 140/90 blood pressure standard for preeclampsia, they did not refute or explain Dr. Wade's testimony based upon the learned treatise that blood pressure and hypertension may vary depending upon the individual involved.

Rigid standards are unsafe because preeclampsia can be an "insidious"[21] process. Wade T. 862:14. This testimony was unchallenged. In simple terms it means that the disease often sneaks up on the woman, without her knowledge, unless she is carefully monitored. She doesn't know, for example, when protein appears in her urine. Therefore, the process toward preeclampsia may be undetected, though inexorable. See Appendix 6, p. 779-80. That's why Dr. Wilde's standard is so dangerous. He relies upon a rigid cut-off of 140/90, which ignores a 24 point DBP increase which falls just short of 90.[22] The disease may progress toward his cut-offs, and may get there before two weeks.

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[21] I.E., progressing imperceptibly but harmfully.

[22] Dr. Wilde admitted that the diastolic blood pressure is more important in assessing preeclampsia, which comports with the medical literature. Wilde T. 1254:3.

There is undisputed evidence about hypertension in Brenda's sister, Julie Vasquez, who was pregnant in 1985. Her records were introduced at trial as Exhibit 39. On the day she was hospitalized, Julie's blood pressure was record as 130/96, which would not have met Dr. Wilde's rigid standard for hypertension. Yet, unquestionably, a diastolic blood pressure that high, would be extremely dangerous. This incident highlights the unreasonableness of Dr. Wilde's position, since by his standard, he would have been justified in doing nothing when presented with a patient such as Julie.

Dr. Wilde's own practice with respect to his other patients indicates that he followed a safer standard with them. Not only did he discuss preeclampsia with patients who did not meet his alleged rigid standard of 140/90 plus proteinuria, but in some cases, he put them at bed rest and/or hospitalized them. See generally, Wilde T. 1317:11-17, 1318. He even brought several patients back in two or three days for retesting for proteinuria and blood pressure, who didn't have proteinuria or 140/90 on the occasion of the previous visit. Wilde T. 1317:18-23.

Plaintiff argues for a more reasonable standard: any significant jump in blood pressure together with a constellation of symptoms, needs to be monitored by the doctor until blood pressure either decreases or treatment for preeclampsia is initiated. This avoids the danger of a rigid standard and is much safer for the women of Utah. Such reasonable monitoring, or even instructions on self-monitoring, would in all likelihood have prevented Brenda's injury.

7. Dr. Wilde Advocates an Inappropriate Research Standard for Clinical Use. Dr. Wilde presented evidence, and convinced the trial court, that there were: (a) at least two respected and acceptable definitions of hypertension and preeclampsia, i.e., 140/90; or a 30 or 15 mmHg increase in diastolic blood pressure; and (b) a difference of opinion as to whether proteinuria was required for the definition; and (c) a difference of opinion as to whether edema, weight gain, nausea and vomiting should be considered as diagnostic signs. The court was apparently confused by, and accepted, this testimony. Accordingly, the court found that there was "a cacophony of opinion, on the subject of the criteria for diagnosing preeclampsia." Finding No. 9. For that reason, apparently, the court found that Dr. Wilde followed an accepted school of thought with his rigid, bright-line standard. However, there was a preponderance of significant, undisputed evidence establishing that Dr. Wilde's definitions, when read in context, were either the standard for a "presumptive diagnosis" of preeclampsia, or originated with authors who were using a "research standard."

Since preeclampsia is an important, serious medical condition that affects tens of thousands of pregnant women every year, many obstetricians write about it. Obviously, researchers seek for uniform standards in research to explain and compare results in order to aid in the learning process. Dr. Wade presented undisputed evidence of "a research standard." He explained:

> Q. Why would it be -- why would there be two different diagnoses, research and clinical? Why is that?

A. Well, if you start trying to add up constellations, this is great and appropriate for clinical practice. But if you're going to write papers about something, you want to be sure everybody is talking about the same thing. So that you set a minimal criteria for research.

Wade T. 970:25 - 971:7. Dr. Wade then read from authoritative writings of Dr. Chesley:

A. "In the day-to-day management, acute hypertension and edema in pregnancy must be regarded and treated as preeclampsia, but in studies of preeclampsia more rigid criteria are essential. Although often of late onset, proteinuria is a hallmark of preeclampsia and the characteristic renal lesions of the disorder are rarely found in the absence of proteinuria.

Many of the diagnoses of preeclampsia in the relevant publications seem to have been made in women without proteinuria." (emphasis added) (quoting from Appendix 10, Article 1, p. 277)

Wade T. 975:14-23, included as Appendix 10. A few moments later, Dr. Wade read again from the work of Dr. Chesley in an article entitled "Mild Preeclampsia, Potentially Lethal for Women and for the Advance of Knowledge" published in the Journal of Clinical and Experimental Hypertension in Pregnancy, 1989. He stated:

Q. I'm going to read this to you. "An increase in blood pressure of pregnant women must be regarded and treated as preeclampsia, for if the patient really has preeclampsia it may progress in severity and lead to eclampsia, or even death.

"In collecting cases for the study of preeclampsia, the working diagnosis cannot be accepted. Far more rigid criteria must be used because hypertension is common to several other unrelated disorders."

Do you agree with that?

A. Yes.

Q. Then on the next page, Dr. Chesley states again:

> "These other surveys mean that in the day-to-day clinical management, any rise in blood pressure in the latter half of pregnancy must be regarded and treated as preeclampsia with a potential for progression to eclampsia, and even to death.
>
> The clinical working diagnosis must not be accepted in publishing studies of preeclampsia, for it is erroneous in at least half of cases and several disorders are lumped together under the name 'preeclampsia', especially 'mild preeclampsia.'" (emphasis added)
>
> Continuing on, "for the diagnosis of preeclampsia, the committee requires the acute onset of hypertension after the 20th week of gestation, together with proteinurea or edema, (facial, digital, or generalized), or both, in their clinically oriented classification they do not require proteinurea because it is often of late onset."

Wade T. 976:14 - 976:17, see Article 2 in Appendix 10. Dr. Wilde gave Dr. Leon C. Chesley a ringing endorsement in his testimony:

> A. To preface that, the fellow who made the statement is Chesley, who is a Ph.D., who has spent more time studying preeclampsia than any other individual in the world. This is a very famous statement of his: "Proteinuria is an important sign of preeclampsia." And Chesley rightly concludes that the diagnosis is questionable in it's absence. (emphasis added)

Wilde T. 1258: 5-11.

This issue clearly points out the problem of context. Dr. Wilde quotes Dr. Chesley, out of context, for the proposition that a diagnosis of preeclampsia without a finding of proteinuria is "questionable." Yet, Dr. Chesley himself, in the same quote in Williams, as noted above, takes the position it is dangerous not to take action when blood pressure rises simply because proteinuria has not yet developed. Dr. Wilde, of course, omits the later part of the quote. As noted, Dr. Chesley makes it very clear that the more rigid proteinuria definition is for research purposes.

The clear weight of the evidence also suggests that in almost every instance of literature where the 140/90 plus proteinuria standards are used in a clinical context, it is used to signify a "presumptive diagnosis." Wade T. 1057-61. In other words, if a patient comes in and has a blood pressure in excess of 140/90 and proteinuria, a doctor may presumptively diagnose her as being pre-eclamptic. That context is important in understanding the literature presented by Dr. Wilde. Typical of that presumptive language is a statement found in Appendix 1 which reads as follows:

> Thus, from pathophysiological and epidemiological perspectives, it is clear that hypertension is the *sine-qua-non* of preeclampsia and that from the moment blood pressure begins to rise, both mother and fetus are at increased risk. Once the blood pressure, exceeds 140/90 mmHg, pregnancy-induced hypertension is diagnosed and the woman is treated accordingly. (emphasis added)

Williams Obstetrics at 655. This quote offers a microcosmic view of Dr. Wilde's error and the court's following thereof. If one looks at only the emphasized portion of the above quote, it could be misread as saying that because one presumptively diagnoses pregnancy-induced hypertension at 140/90, one doesn't have to take any action or watch the patient before the woman hits 140/90. That's Dr. Wilde's position in a nutshell. However, the first sentence of this same passage points out that both mother and baby are at increased risk "the moment blood pressure begins to rise."

Two sentences before that passage, Williams also states: "when the blood pressure rises appreciably during the later half of pregnancy it is dangerous, to the fetus especially, not to take action simply because proteinuria has not yet

developed." (emphasis added) Thus, by reading this entire passage in context, a fair reader can clearly see that this piece of literature is not arguing just because a presumptive diagnosis of PIH exists at 140/90, that the doctor can wait and do nothing, as Dr. Wilde advocates, just because the patient's blood pressure has not yet reached 140/90. Regardless of the definition of PIH or preeclampsia, to imply that inaction is proper in the face of an increasing diastolic blood pressure and the other constellation of signs and symptoms is simply wrong. Dr. Wilde is improperly viewing preeclampsia as though it's not there one minute, then present the next. In the clinical setting, that approach is very dangerous given the progressive and insidious nature of preeclampsia. Appendix 6, p 779. Wilde's position boils down to the attitude of "I don't have to watch this condition unless Brenda Rivera meets a bright-line standard of 140/90 and proteinuria." That approach will surely kill patients, if actually exercised by Dr. Wilde, because it ignores many patients who should be monitored.

8. The Literature on Preeclampsia. Plaintiff has largely dealt with this issue in the point immediately above. One additional, distinct point is important. Finding No. 9 reflects the court's belief that the literature is a state of total confusion. Some different viewpoints are expressed in the literature regarding definitions and some peripheral aspects of preeclampsia. However, there is no substantial difference of opinion in the literature on the main point in this case: whether an obstetrician can wait to take action with a patient similar to Brenda Rivera, until she reaches the rigid, bright-line thresholds of 140/90 and proteinuria.

Dr. Wade's testimony is found in the record as T. 839-1080. About two-thirds of Dr. Wade's testimony on direct consisted of Dr. Wade reading into the record from learned obstetric texts and articles published in the 1980's, mostly in the late '80s. In fact, Dr. Wade read excerpts from at least 28 different authoritative texts addressing the clinical diagnosis and treatment of preeclampsia. Wade T. 889, 891, 895, 897, 899, 902, 903, 905, 908, 913, 915, 918, 920, 922, 923, 925, 926, 929, 932, 965, 973, 974, 976, 982, 987, 995 and 996. Many of these quotes deal with the clinical necessity of taking action when faced with rising blood pressure and a constellation of signs and symptoms that could indicate preeclampsia. Many of these authors do not agree on the precise definition of preeclampsia, but they uniformly agree with the necessity of taking action prior to the time the patient meets a bright-line criteria. In fact, no author in any article cited by either the defense or plaintiff, has taken a contrary position in the literature.[23]

When quotes are taken out of context, they may appear to support arguments advocated by the defendant. Another classic example is Dr. Wilde's discussion of the significance of edema. Dr. Wilde, based upon Williams Obstetrics, criticizes the 30/15 mmHg increase for hypertension and the importance of generalized edema. He read an excerpt observing that the 30 SBP or 15 DBP increase is not diagnostic of PIH and is a "vague criteria" with "little clinical value."

[23] The possible exception is an article cited by the defense that, when read closely, is simply criticizing the different research standards in writings throughout the world, not advocating a practical clinical standard. Wilde T. 1259-60.

Wilde T. 1257:2-14. He then skips to the next column with the discussion of generalized edema, also used by some in the diagnosis of preeclampsia, and reads a passage which says that many authorities concur that edema, even in the hands and face, is such a common finding "that its presence should not validate the diagnosis of preeclampsia any more than its absence should preclude diagnosis." Wilde T. 1257:12-15. In each instance, Dr. Wilde brazenly ignores contextual language in the same paragraph, in the one case in the very next sentence. In the quote about "vague criteria," the next sentence reads: "Such findings [30 or 15 mmHg increase], however, may increase the risk for pregnancy-induced hypertension." (emphasis added) Williams at 654, Appendix 1. The balance of the paragraph reports a 1988 study by the well-known preeclampsia researcher Marco Villar which showed that women with a 15 mmHg rise in diastolic blood pressure, or greater, were twice as likely to develop PIH as those without the rise. Id. With respect to the edema quote, the context reveals that the criticism was of the use of "generalized edema" alone. That same paragraph which Dr. Wilde quoted in part ends with this sentence:

> Thus, the edema of preeclampsia is pathological and not dependent, and it usually involves the face and hands and persists even after arising. A useful indicator of non-dependent edema is the woman's complaint that her rings have become too tight. (emphasis added)

Id. This latter section was read and relied upon by Dr. Wade. Wade T. 922.

Dr. Wilde brazenly quoted literature out of context. Most importantly, however, Dr. Wilde never offered anything to show any of the

literature advocated a clinical stance of waiting until a woman achieves his threshold before acting to protect her.

9. Constellation of Symptoms and Waiting. Plaintiff offered undisputed evidence through Dr. Wade and voluminous authoritative literature that it is unsafe to wait for 140/90 and proteinuria, and not to take action when faced with a constellation of signs and symptoms, such as Brenda Rivera had on June 15, 1989. The constellation could indicate developing or existing preeclampsia. Wade T. 915. See Ex. 38, a chart used at trial, also attached hereto as Appendix 13. Dr. Wilde was then challenged to find any article among the dozens present in the court room that supported his position that he could wait and not act in the face of the admitted constellation of symptoms. Dr. Wilde could not produce such an article. Wilde T. 1312-15. This court needs to appreciate the context of his answer in light of the fact that both sides were using thick notebooks choked with articles, book chapters, and the like. Both sides had exchanged these voluminous materials and therefore had plenty of time to review them. Dr. Wilde was virtually the last witness of the two week trial, and so had ample time to familiarize himself with the data in the article notebooks. The questioning went as follows:

> Q. Doctor, I lay before you all of the medical and journal articles that have been referred to in this court. It looks like it comprises perhaps 500 or more pages. Maybe 700 or 800. Find me one single article -- one -- one -- that says that when a patient presents with the constellation of symptoms like that, constellation of symptoms, that you don't have to treat.
> A. Again, if this patient does not have preeclampsia she does not need to be treated. You do not treat people for disease they do not have.

> Q. Then find me an article, while you are looking, that says that a person with that constellation of symptoms and weight gain can be invited back in two weeks.
>
> [Mr. Williams, defense attorney, makes objections which are overruled]
>
> Q. (By Mr. Sykes) Let me ask the question: Does any particular article that has been referred to in the court room come to mind, doctor?
>
> A. Six, I believe. . . .
>
> Q. Can you find me a statement there that says all those facts as considered together do not warrant some action on your part?
>
> A. I don't know that that's possible in a short period of time.

Wilde T. 1309:4-1310:2. The article in question is attached as Appendix 11 and the Court can clearly see that there is no such reference.

Dr. Wilde and the trial court really missed the whole issue here: Regardless of one's definition, can Dr. Wilde send Brenda Rivera away given her clinical condition without making provision to monitor what could be developing or existing preeclampsia? In other words, can he wait? There is a clear absence of evidence from Dr. Wilde, aside from his self-serving testimony, that the standard allows him to "wait." However, there is a massive amount of evidence that says that he has to monitor or treat a person with Brenda's constellation of symptoms. He clearly violated the standard of care.

10. Easy Method of Monitoring or Detecting, Developing or Existing Preeclampsia. Dr. Wilde's standard misses or delays detection of developing or mild preeclampsia. He rationalizes this by claiming that in a busy

practice, one has to have cutoffs, and 140/90 plus proteinuria is a reasonable cutoff to avoid being swamped with the treatment of women for preeclampsia who don't really have it. He claims this is safe because preeclampsia is "an extremely remote risk" in women under thirty weeks. Wilde T. 1290:1-13. Both Dr. Farnsworth and Dr. Wilde will have us believe that it's a practical kind of clinical practice necessity to have these cutoffs, in a large practice such as theirs. Wilde T. 1294, 1311:9-11; Farnsworth T. 1117:5-24.

Contrary to Dr. Wilde's position, plaintiff advocates a standard of watchfulness for patients like Brenda Rivera, not one that would inundate an obstetric practice. It is clear from the discussion above that many doctors would have diagnosed Brenda on the spot as being preeclamptic because she had a 24 mmHg increase in DBP on 6/15/89. It is also clear that it would be appropriate, under that view, to at least put Brenda Rivera at bed rest and check her again within hours or a day or two. Dr. Wade, for example, testified he would have rechecked her at no later than 48 hours. Wade T. 976:12-22. In any event, under the undisputed facts of this case (when read in context), the least that was required of Dr. Wilde was to monitor Brenda's blood pressure at least six hours after it had been measured at 88. Every text that addresses monitoring of blood pressure, requires the measurements at least 6 hours apart. Dr. Wilde himself was emphatic when he said that the measurements must be 4-6 hours apart. Wilde T. 1254:4-5. See also Wade T. 869:2-10; Williams at 653 - 4. Obviously, three measurements taken in a 10-minute period are not going to reveal the sustained presence of

hypertension, particularly when one of the measurements is taken when the patient is lying down. Wade T. 910:23-25, 911:1-2.

This 6-hour requirement emphasizes why Dr. Wilde's standard is so unsafe, and that advocated by plaintiff is so reasonable. When Dr. Wilde left the examination room on June 15th, after having initially suspected that Brenda had preeclampsia, in part because of the significant spike in her diastolic blood pressure, he had no way of ascertaining what her blood pressure would do in the future, for at least before two weeks. He violated his own rule that required two measurements in "4-6 hours." In essence, from that point on, Brenda was on her own, with the general warning to "call if you need anything."

Under plaintiff's suggested standard, the minimum Dr. Wilde was required to do is to remeasure the blood pressure sometime after his own 4-6 hour standard. How difficult would this have been? The court can surely take judicial notice of the fact that blood pressure is fairly simple to measure. Brenda could have her blood pressure tested later that same day (if her appointment was in the morning) or during the next day or two, right at the doctor's office, by a nurse. Nurse Kuehn took one of the three blood pressure readings on 6/15/89. Kuehn T. 1537:15-17. It would have cost the nurse at the doctor's office perhaps 1-2 minutes of time, and the patient wouldn't even have to see the doctor (unless the blood pressure remained high, in which case the doctor would definitely want to see the patient).

Blood pressure can be self-measured with equipment commonly available at drug stores. Retesting the blood pressure is, of course, highly confirmatory of the condition of preeclampsia. If it goes higher or remains high, or reaches 140/90, the diagnosis of PIH is confirmed. If it goes lower, the doctor can recognize that it's a false alarm. At least there would be some confirmation. Dr. Wilde said he didn't think Brenda's blood pressure would go back up on 6/15/89, but how did he know? Without following his own standard of taking the measurement twice at least 4-6 hours a part, he couldn't possibly know. It was just a wild guess. A second blood pressure reading was a must.

A repeat blood pressure reading is simple, easy, harmless, inexpensive and highly reliable -- just like the glaucoma test in Helling v. Carey. The Washington Supreme Court simply did not accept the defendant ophthalmologist's lame explanation that the standard of care didn't require such a test for patients under 40, despite the patient's symptoms of glaucoma. The undisputed evidence at trial was the incidence of glaucoma in such patients was only 1 in 24,000. However, there, as here, the failure to administer such a test could be, and was, disastrous for the patient. Even though the ophthalmologist followed the local standard of care (undisputed), the Washington Supreme Court held that the standard was unsafe, and the lower court need not accept it or follow it. The case *sub judice* is almost a mirror image of Helling v. Carey.

The same argument applies to a proteinuria standard. Dr. Wilde was relying on the presence of proteinuria for his diagnosis of preeclampsia. Even

taking his standard at face value, it is hard to imagine a positive protein test being detected with two dipsticks in the same urine administered maybe 20-30 minutes apart. See Tony Rivera T. 1359:1-3. The ACOG standard requires two urine specimens at least 6 hours apart. Dr. Wilde was in no position to know whether Brenda Rivera would be developing proteinuria over the next 6 hours, or over the next day or two. If Brenda had come back in 24-48 hours and had 140/90 plus proteinuria, he presumably would have initiated treatment, but she was robbed of that chance. The urine test is likewise simple, inexpensive, harmless, convenient and highly confirmatory. It amounts to putting a dipstick in the urine sample to see if it changes color. Wilde T. 1281:9-17. Dr. Wade testified that protein in the urine could easily be checked at home with a dipstick. Wade T. 983-4. This testimony was undisputed and unchallenged. Dr. Wade also testified, again undisputed and unchallenged by the defense, that had the protein been monitored and checked regularly between 6/15 and 6/23/89, the protein increase would have been picked up. Wade T. 983.[24] Dr. Wilde did it himself twice during the June 15th visit. Wilde T. 1288:1-3.

Dr. Wilde's claim that adopting plaintiff's standard would inundate his practice with follow-up visits by women who aren't really preeclamptic is a straw-man argument. However, if not definitively diagnosed as preeclamptic on

[24] Dr. Farnsworth agreed in his deposition that this would have been picked up with monitoring. Farnsworth depo. 73:8-19. At trial, Dr. Farnsworth tried to deny that the condition would have been picked up, but plaintiff read his deposition to him where he agreed that it would have been picked up. Farnsworth T. 1188-9.

that visit, Brenda should at least have been watched and retested until a definitive diagnosis could be made. Secondly, Dr. Wilde makes a big deal about "access." He claims that access to him is the hallmark of his practice and that every patient always feels that she has total access and can call anytime she wants. Wilde T. 1277.[25] How can a doctor who makes such a big deal out of "access" on the one hand, imply that having Brenda Rivera come back for repeat blood pressure and urine readings would somehow overtax his office?

Dr. Farnsworth claims that in a large practice, an obstetrician has to practice "triage." Farnsworth T. 1157:7. "Triage" is a practice carried out on the battlefield whereby some victims are treated based on their high likelihood of survival, and others are not treated because of their low survival possibility. Needless to say, the practice of "triage" should not be countenanced in a routine obstetrical practice. An obstetrician would only have to monitor women with Brenda's symptoms by repeating their blood pressure and protein readings until it was determined that they weren't rising. Furthermore, Dr. Wilde's evidence in this respect is highly unbelievable because he claims on the one hand that this practice would basically create management problems for him (Wilde T. 1294:5-16), but on the other hand claims that Brenda's condition is so rare that it amounts to 1 in 100,000 probability. Wilde T. 1290:1-7. Which is it? Too common or too rare?

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[25] On the other side of the coin, Tony Rivera's testimony is that he was discouraged from bringing Brenda in on June 12th by Dr. Wilde's nurse; Dr. Wilde was an hour late seeing them on 6/15/89; and that he hurried through the examination, having some conversations on the way out the door. Tony Rivera T. 1359:4-12.

Dr. Wilde's claim that one of every four patients is like Brenda (Wilde T. 1294) is also obviously a gross exaggeration. Preeclampsia is almost exclusively a condition of first pregnancy. Wade T. 875:2; Williams Obstetrics at 655-7. Therefore, other patients who have had children are not at as high a risk for preeclampsia, even with the same symptoms.

11. The Alleged Careful Examination. Dr. Wilde claims that he did a careful examination of Brenda on 6/15/89 and did not feel that she had preeclampsia when she left the office. Wilde T. 1314:10-17. Nor did he feel that she would develop it in the next two weeks. Wilde T. 1311:9-17. Dr. Wilde claims that he looked at every symptom and was able to somehow explain it away. For example, he was gratified that the blood pressure had declined to 110/80 at the time Brenda left. Wilde T. 1289:4-10. The undisputed evidence demonstrates that Dr. Wilde had sufficient medical reason to monitor Brenda's condition sooner than two weeks and that his examination, even if as careful as he alleges, was not sufficient to detect developing preeclampsia that might be evident in a day or two.

Dr. Wilde was clearly aware that Brenda's condition when she left the office on 6/15/89 was not "normal." First of all, he took her blood pressure three times, instead of the normal one time per visit. Wilde T. 1278:16-19, 1279:7-12, 1289:4-8. He measured her urine twice, rather than the normal once. Wilde T. 1288:1-3. He asked her to come back in two weeks, rather than her normal four. Wilde T. 1291:4-5. He discussed preeclampsia (toxemia) with her. Wilde T. 1287:15-25, 1288:11-17. He allegedly advised her to stay off her feet as much as

possible when she got home, and to take breaks at work. Wilde T. 1292:5-9. She had the associated signs and symptoms of preeclampsia. With all of this evidence, he clearly had enough reason to monitor her condition.

Dr. Wilde's continuing duty to monitor is emphasized by the undisputed evidence, from his own mouth, that protein and blood pressure measurements must be taken at least 6 hours apart. Wilde T. 154:3-6. Single, isolated readings are not enough (Williams Obstetrics at 653) and surely multiple readings within 15-30 minutes are not sufficient to pick up the progression of a disease, the condition of which can change rapidly.

One examination, though it is allegedly "careful," is not enough to pick up changes in blood pressure and protein which may occur in the future. Furthermore, there was no evidence of a standard of care that says that a doctor can do one careful exam for preeclampsia and wait two weeks to see the patient. Wilde T. 1308 - 1310. In fact, all the evidence is to the contrary, that preeclampsia warrants more careful monitoring. Dr. Wilde's own conduct in taking the blood pressure reading three times, the protein reading twice and having her come back in two weeks instead of four, in a perverse sort of way, evidences that standard. The folly of this argument of a "careful" examination is clearly demonstrated by two undisputed facts: (a) there is admittedly no way one could confirm with absolute certainty, by one examination alone, whether Brenda had or was developing preeclampsia (there must be multiple readings 6 hours a part); and (b) Brenda's condition deteriorated until 6/23/89. If a patient like Brenda was developing or had

mild preeclampsia when Dr. Wilde saw her on 6/15/89, one would expect her condition to deteriorate. However, the undisputed evidence was that a woman developing preeclampsia will have signs such as higher blood pressure, proteinuria and weight gain which could easily develop unnoticed by the patient. Wade T. 862:14. See for example Appendix 6, pps. 779-80. That evidence is uncontested.

Dr. Wilde claims that he told Brenda to call if she got any worse. Wilde T. 1288:18 - 1289:3. However, how would Brenda know if she developed protein in the urine or a blood pressure of 140/90?

Tony Rivera testified, without dispute, that he and Brenda were determined to follow Dr. Wilde's advice to see if she improved. She began drinking more water, stayed off of her feet as much as possible, etc. Tony Rivera T. 1361:13-19. It was only when it was clear that she was not getting better and her condition began to worsen that they decided on the evening of 6/22/89 to call Dr. Wilde the next morning and make an appointment. Tony Rivera T. 1364:6-12. When Tony called around 9:30 a.m. to see if Brenda was ready, he got no answer, and after several more phone calls, finally sent Brenda's sister over who found Brenda in a coma on the bed. Tony Rivera T. 1378-81.

There is considerable undisputed evidence in the record to call into question Dr. Wilde's testimony that he gave such a careful, detailed examination. First, he claims that he looked very carefully at Brenda and did see any facial edema (the pathological kind that results from preeclampsia), although he admits that Tony complained of facial edema. Wilde T. 1280:13-20. However, Tony

Rivera had no memory of such a detailed examination or conversation. Tony Rivera T. 1355:13-23. Brenda tried to get an early appointment in the first place because her janitorial colleagues at the University of Utah Medical Center thought she had "toxemia," because of her facial swelling. It seems disingenuous for Dr. Wilde to therefore claim that he didn't see any facial swelling, rejecting not only the admitted statements of the janitorial colleagues (Wilde T. 1287:23 - 1288:10) but also the statements of her husband, who knew her well. In other words, to believe Dr. Wilde, we must believe that an allegedly careful doctor performed a careful examination for facial edema for a patient seen only four or five times previously. Presumably, he did not know her well but still rejected some pretty significant evidence about the facial edema.

Furthermore, Dr. Wilde alleges that he thought Brenda had the flu. Wilde T. 1288:11-17. If that is so, why is there no mention of that in his record of 6/15/89? Why didn't he give her anything to help this condition? Why did he believe she had the flu in the first place, when she had been complaining of these conditions from early in her pregnancy? Wilde T. 1283:1-9.

The undisputed facts show that Dr. Wilde had plenty of reason to monitor Brenda Rivera's condition closely. It was beneath the standard of care to send her away for two weeks. It is clear that Dr. Wilde's alleged "careful examination" was not the reason that Brenda was not diagnosed or further monitored for preeclampsia. Dr. Wilde clearly stated that his reasons for taking

no action were simply that Brenda did not meet the rigid, bright-line criteria of 140/90 plus proteinuria. See Point I.B. Finding of Fact No. 12 states:

> During defendant's examination and evaluation ... the possibility of preeclampsia was raised, but there was nothing ... which was diagnostic of preeclampsia or developing preeclampsia. To the contrary, plaintiff did not have hypertension or proteinuria. (emphasis added)

If anything is clear from defendant's evidence, it is that a woman need not be diagnosed or monitored for developing preeclampsia until and unless she meets the rigid, bright-line standard. It's unsafe.

POINT II

DR. WILDE'S STANDARD IS UNSAFE AS A MATTER OF LAW.

> **Dr. Wilde's reliance on an arbitrary, rigid standard for the diagnosis of preeclampsia, i.e, that the patient must have a blood pressure of 140/90 and proteinuria, is unsafe as a matter of law. The condition is potentially life-threatening and if untreated can fulminate to eclampsia within a matter of hours or days. There exists a relatively simple, harmless and inexpensive means to confirm or exclude the diagnosis. It is therefore unsafe as a matter of law to instruct the plaintiff to return in two weeks.**

The court found that plaintiff had not demonstrated by a preponderance of the evidence that "the school of thought that defendant followed is not accepted, insufficient or unsafe." Finding of Fact No. 11. This finding is based upon Findings 6 and 10. See Point I.B.

The plaintiff proved at trial, as a matter of law, that the "wait until 140/90 plus proteinuria" standard was unsafe. The discussion above in Point I establishes the insufficiency of the court's finding that the standard was safe; it also demonstrates that the standard was unsafe. Therefore, the discussion in Point I is incorporated here by reference. A few additional comments will suffice.

It is uncontested that there are different definitions of hypertension and preeclampsia. Perhaps these are appropriately termed as "schools of thought." Clearly, a substantial portion of the medical community would have diagnosed Brenda Rivera as preeclamptic by virtue of greater than 15 mmHg increase in diastolic blood pressure on 6/15/89. Others might have waited. But all the credible evidence suggests that at the very least, Brenda should have been watched and monitored. The evidence is very strong that proper monitoring would have picked up the condition, since eclampsia is very rare because of good prenatal treatment. Brenda was entitled to that chance.

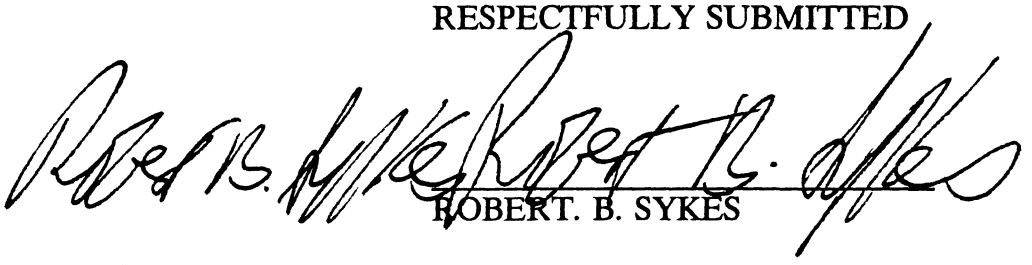
In the final analysis, Dr. Wilde violated the standard of care by sending Brenda away for two weeks when the undisputed evidence indicates that preeclampsia could develop or progress to a dangerous state in a far shorter time. In fact, this is exactly what happened. As a matter of law, Dr. Wilde's conduct was therefore unsafe.

CONCLUSION

There was insufficient evidence to sustain Dr. Wilde's school of thought for monitoring and diagnosing preeclampsia. Where Dr. Wilde's alleged school of thought advocates waiting until a patient has a blood pressure of 140/90 with proteinuria, and the undisputed evidence shows that preeclampsia may develop or be present without meeting those criteria, Dr. Wilde's standard must be deemed unsafe for the public. Therefore, there was insufficient evidence as a matter of law to establish Dr. Wilde's standard was safe, and the undisputed evidence established that it was unsafe. Accordingly, the decision of the trial judge must be reversed.

DATED this 15th day of December, 1993.

RESPECTFULLY SUBMITTED



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CERTIFICATE OF SERVICE

I hereby certify that ~~four~~ two true and correct copies of the foregoing Appellant's Brief was served upon the parties at the addresses listed below, by hand delivery on the 15th day of December, 1993.

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